Improvement Academy

Humber and North Yorkshire Health and Care Partnership

Exploratory tool for understanding why a fall may have occurred, share learning and good practice to prevent future incidents

Step 1 – Complete timeline

Step 2 – Capture the teams (& residents) perspective re why it happened

Step 3 – Complete the Yorkshire Contributory Factors Framework (YCFF)

Step 4 – Capture the key contributory factors and areas of good practice

Step 5 – Share the report

Details		
Setting:		
Name and position of person completing form	Date completed	Date fall occurred

Step 1 – Timeline of event if appropriate/ Brief description of what happened

Date & Time	Event Overview e.g. relevant information leading up to the incident if appropriate such as medication review/ change in condition, new to the care setting etc and include brief description of what happened	Actions taken

Step 2 – Gaining a holistic view

Care setting professional perspective on what happened but may also include others (Residents & other visitors i.e. GPs, DNs where possible)

Step 3 - The Yorkshire Contributory Factors Framework- (adapted for Care settings by NHS HNY ICB with permission from YHIA)

Domain 1: Situational Factors		
Team factors		**Comments**
Did a reduction or change in teamwork contribute to the fall? *For example:* • Unclear team aims • Lack of respect for colleagues • Poor adherence to guidance/ policy • Poor delegation for jobs • Absence of feedback	☐ Yes ☐ Maybe ☐ No	

Individual staff factors		
Were there any reasons this fall was more likely to occur with the particular staff involved? *For example:* • Tiredness • Stressed • Rushed • Personal & religious beliefs • Distracted • Inexperience • Agency • Staff moving between different homes	☐ Yes ☐ Maybe ☐ No	
Task characteristics		
Did the care provision make the fall more likely in this setting? *For example:* • Unfamiliar tasks required of care /nursing team • Difficult task • Monotonous task	☐ Yes ☐ Maybe ☐ No	

Resident factors		
Were there any reasons the fall was more likely to occur in this group of residents? *For example:* • Language barrier • Uncooperative • Complex medical history • Learning disability • Unusual physiology • Dementia • Mental health • Cognitive impairment • Nursing Needs	☐ Yes ☐ Maybe ☐ No	

Domain 2: Local Working Conditions

Workload and staffing issues

Was there a reduction in staff hours, workload and staff numbers around the time of the fall? *For example:* • Increased workload • Staff absence • Reduction in staffing levels due to dependency levels at the home. • Inability to access or use agency staff	☐ Yes ☐ Maybe ☐ No	

Leadership, Supervision and Roles

Was there visible management and leadership at the time of the fall, with a support network for staff? *For example:* • Unclear responsibilities • Inappropriate delegation • No Registered Manager in place • Role modelling from senior team • Lack of direction and supervision • Was wellbeing support provided?	☐ Yes ☐ Maybe ☐ No	

Drugs, Equipment and Supplies

Were there difficulties obtaining the correct drugs and/or working equipment and/or supplies? *For example:* • Medication supplies • Moving & Handling equipment not working or access to services • Unavailable equipment/ delivery issues • Cleaning & storage of equipment e.g. hoists/ commodes • Inadequate maintenance	☐ Yes ☐ Maybe ☐ No	

<table>
<tr><th colspan="3">Domain 3: Organisational Factors</th></tr>
<tr><th colspan="3">Physical environment</th></tr>
<tr><td>Did limitations in the home environment play a part in the fall occurring?
For example:
• Poor layout
• Lack of space
• Shared rooms
• Poor visibility of residents
• Open plan living areas
• Excessive noise/ heat/cold
• Poor lighting
• Poor access to resident</td><td>☐ Yes
☐ Maybe
☐ No</td><td></td></tr>
<tr><th colspan="3">Support from other professionals</th></tr>
<tr><td>Did problems from other agencies play a role in the fall occurring?
For example:
• This includes support from clinical services such as DN, GPs, UCPs/YAS, community pharmacy, community therapies, LA, IPC team, PH, CQC, ICB</td><td>☐ Yes
☐ Maybe
☐ No</td><td></td></tr>
<tr><th colspan="3">Bed management & interface with other agencies</th></tr>
<tr><td>Were there any issues or concerns with admissions or discharges / bed pressures that may have played a role in the fall?
For example:
• Issues with an admission
• Transfer inappropriate to needs of resident
• Delay in the provision of care
•
• Lack of out of hours support
• Handover on trusted assessment or conversation tool
• Funding stream issues
• Trusted Transfer Document not used</td><td>☐ Yes
☐ Maybe
☐ No</td><td></td></tr>
</table>

Staff training and Education		
Did issues with staff skill or knowledge play a role in the fall occurring? *For example:* • Inadequate falls prevention training • Not enough/ protected time for training and development • Practice not up to date with falls prevention guidance • Medication awareness • No regular updates • Training nor standardised • Lack of supervision	☐ Yes ☐ Maybe ☐ No	

Domain 4: External Factors		
Design of Equipment, Supplies and Drugs		
Did any characteristics of the equipment, disposables or drugs play a role in the fall occurring? *For example:* • Confusing equipment design • Equipment not fit for purpose i.e. HSE approval • Unclear labelling and packaging • Equipment not appropriate to task	☐ Yes ☐ Maybe ☐ No	
National/local policies & guidance		
Did the lack of implementation of relevant policies, procedure or best practice play a part in the fall occurring? *For example:* • Commissioned resources • National & Local policy • Conflict local vs other guidance • Auditing – Quality Assurance requirements. • CQC Regulatory Framework • Organisational guidance/policy • IPC requirements	☐ Yes ☐ Maybe ☐ No	

Domain 5: Communication and Culture

Safety culture

Did the safety culture in your home play a part in the fall occuring?		
For example: • Resident capacity for safety awareness • Documenting errors • Reporting of incidents • Staff ownership/responsibility • Attitude to risk management • Fear of asking questions • Business reputation	☐ Yes ☐ Maybe ☐ No	

Verbal and Written communication

Was written and verbal communication effective?		
For example: • Poor communication between staff • Effective handover • Lack of communication/notes • Newsletters & Residents meetings • Keeping relatives and friends informed • Unable to contact correct staff • Issues with electronic systems • Unable to read notes • Lack of guidance and posters shared with staff re required practice and behaviours	☐ Yes ☐ Maybe ☐ No	

Step 4 – Summary of key contributory Factors

Domain 1 – Situational Factors

Domain 2- Local Working Conditions

Domain 3 – Organisational Factors

Domain 4-External Factors

Domain 5- communication

Areas of good practice to be shared

Are there key actions to be taken following this to support best practice?

Step 5 – Sharing of the learning	
Date	Shared with?